Part B Insider (Multispecialty) Coding Alert

SPLIT/SHARED VISITS: CMS Clarifies Split/Shared Visit Rule Now That Consults Are No Longer Payable

Plus: CMS reps cite current Medicare law and advise that practices should report just one inpatient care code per patient, per day.

Although CMS has eliminated payment for consult codes, it will continue to honor split/shared visits -- as long as they are billed using E/M codes and follow the payment rules already in place.

That's the word from CMS, where staffers aimed to straighten out confusion stemming from the January MLN Matters article SE1010, which offered several questions and answers regarding how to bill Medicare following the elimination of consult code payment.

In the article, CMS noted that "the split/shared rules applying to E/M services remain in effect, including those cases where services would previously have been reported by CPT consultation codes."

"We understand that this has caused some confusion, as there were -- and are -- different split/shared rules for consultation services compared to E/M services," noted CMS's **Rebecca Cole** noted during during an April 13 CMS Open Door Forum.

"We'd like to clarify that Q&A,"Cole said. "As we're no longer recognizing the consultation CPT codes for purposes of payment under Part B, the split/shared rules regarding consultation services are no longer applicable. Since E/M visit codes are being billed for services that were previously reported by the CPT consultation codes, the split/shared rules pertaining to E/M services apply when billing E/M CPT codes," Cole stressed.

Remember: You can still report shared/split visits according to the regulations using E/M codes, but you cannot collect from Medicare for any consultation codes.

CMS is considering issuing a clarification in writing to dispel any confusion regarding the shared/split billing rule, Cole noted.

CMS Advises Practices to Rein in Initial Inpatient Billing

One caller wanted clarification on billing for hospital care now that consult codes aren't payable. She asked whether a physician can report two initial hospital care codes for the same patient on the same date -- for instance, if the physician saw the patient prior to surgery for one reason, and then saw the patient after surgery for another reason.

"I think you should consult the CPT rules as well as the manual, but I think our reaction to that is no," said CMS's **William Rogers, MD,**during the call. The initial hospital care codes refer to that physician's first visit with the patient, Rogers said. Later evaluations should be billed using subsequent hospital care codes, he advised.

However, CMS reps indicated that they will look into the issue further to determine whether physicians should be able to report a second initial hospital care code if specifically requested to review a different condition. "We can consider this further and decide what our next steps will be," Rogers said. Until then, CMS staffers urged practices to continue billing according to published rules.

In black and white: "Both initial inpatient hospital care codes and subsequent hospital care codes are 'per diem' services and may be reported only once per day by the same physician or physicians of the same specialty from the same group practice," notes CMS Transmittal 1545.

Use Current Bone Density Codes

One caller was delighted that, thanks to the new health care reform legislation, CMS will be raising payment for bone density tests, but noted that the legislation listed old bone density test codes 76075 and 76077.He asked whether MACs will be requesting those codes going forward, or whether practices should continue reporting newer codes 77080-77082.

Advice: You should use the current codes 77080-77082, not the old codes, said CMS's **Amy Bassano.**